CTAMFT

CONNECTICUT ASSOCIATION FOR
Marriage & Family Therapy

March 15, 2022

The Honorable Matt Lesser, Co-Chair
The Honorable Kerry Wood, Co-Chair
The Honorable Tony Hwang, Ranking Member
The Honorable Cara Pavalock-D'Amato, Ranking Member
Insurance and Real Estate Committee
Connecticut General Assembly
Legislative Office Building, Room 2700
Hartford, CT 06106

RE: SB 360: An Act Concerning Various Changes to Utilization Review Companies Licensure Statute and HB 5391: An Act Concerning Mental Health.

Chairman Lesser, Chairwoman Wood, Vice Chairman Anwar, Vice Chairwoman Comey, Ranking Members Hwang and Pavalock-D'Amato and members of the Housing Committee:

My name is Rebecca Ruitto, I am a Licensed Marriage and Family Therapist (LMFT) and the Chair for the Connecticut Association for Marriage and Family Therapy (CTAMFT). I am a resident of Portland and own a private mental health practice in West Hartford. I am writing in support of SB 360 and HB 5391, with requested modifications to reduce barriers imposed by private insurance carriers on mental health providers in Connecticut.

CTAMFT currently represents over 1,500 licensed Marriage and Family Therapists (MFTs) through-out Connecticut. Marriage and Family Therapists are employed in various clinical settings throughout the state, serving diverse mental health needs. Marriage and family therapists are specifically trained through a systemic lens, and have extensive training in treating individuals, couples, families and systems as problems arise. Additionally, many MFTs are in network with the various private insurance carriers that operate in our state.

As you know, Connecticut is faced with a mental health crisis affecting adults, children and families in Connecticut. Many mental health providers are at full capacity and have waiting lists for new clients. Many facilities that offer higher levels of care are at capacity and have extensive waitlists; placing outpatient providers in a difficult situation to manage higher level needs in less time and inappropriate settings.

We, as mental health providers, are doing all we can to address this crisis. Many MFTs in private practice do not have administrative support or have limited administrative support. As a result, administrative burdens erected by private insurance companies place a significant burden on our profession. These barriers include: ever changing claim submission procedures; lengthy waits for service reimbursement; frequent audits; claw-backs of previous payments and erroneous claim denials.

These issues are driving mental health providers to remove themselves from provider networks. Those providers that choose to stay in-network are bogged down by time consuming paperwork and phone calls that could otherwise be used servicing Connecticut residents in need of mental health treatment.

Our members have informed us of the following specific obstacles in the private insurance market:

- Delays in claim processing times as a result of claims being stuck in the "accepted" stage of processing for extended periods of time, often lasting several weeks to several months.

- Frequent or sudden changes to insurance processing systems resulting in claims being rejected and resubmitted. When original claim processing is delayed, the resubmitted claims are then rejected due to being "outside the timely filing window."

- Insurance carriers do not update declared changes in their claim submission system in the same timeframe they require providers to change claim submission procedures. So despite providers submitting necessary forms correctly and on time, the insurance carriers' systems aren't ready for changes, resulting in additional rejections and delays.

- Difficulty in communicating with insurance companies to correct errors or dispute rejected/denied claims as needed due to being placed on hold for extended periods of time (30 minutes+).

- Increased and repetitive insurance audits of providers requesting records over large spans of time with unclear or varying documentation requirements, sometimes resulting in payouts being recouped. These audits often require constant justification of session duration and frequency despite the provider's clinical recommendations of diagnosis and treatment modality.

- Claw-backs in the form of notices from insurance carriers to providers indicating an overpayment and requesting immediate payback. These have increasingly been for overpayments from months to years prior to the service being rendered, and with delays in payments of current providers.

- Rejections of classifying mental health providers as in-network providers due to "too many providers in network area", thus lessening availability of in-network providers for residents to receive treatment. 56% of membership survey responses indicated they were unable to join a panel due to private insurance companies denying their application due to "full/saturated" areas despite ongoing referrals inquiring for their services. Additionally, many providers report this process is taking months to complete, thus delaying their ability to start treating clients.

- Untimely updates to in-network provider rosters and provider contact information; leaving residents seeking treatment with inaccurate provider information or providers not being able to access payments or notices due to incorrect mailings.

- Incorrect explanation of benefit (EOB) sent to wrong providers, with incorrect client information or policy information causing time consuming holds to rectify.

- Poor reimbursement rates, including denials for rate increases spanning over 10 years from some

insurance companies. Denials of rate increases make it more difficult for providers to continue to manage increased cost of living and business-related expenses. Many move to private pay so that they can remain profitable enough to pay overhead expenses.

We request that the study referenced in HB 5391 be carried-out by an independent task force that has representation from the Department of Insurance, (DOI) but not conducted by the Department. We also request that you utilize the task force outlined to review and recommend adjustments to private insurance regulations to reduce barriers and support private practitioners and mental health agencies.

CTAMFTs recommends that the taskforce consider the following topics to review and provide recommendations on:

- Improved communication between providers and insurance representatives through regular updates to insurance panel lists of in-network providers.

- The development of systems and protocols that decrease claim processing times through standardization efforts for claims pending in “accepted” or “processing” status for extended periods of time. Systems and protocols should reduce errors and inaccurate denials of payment of claims.

- Creating clear guidelines for claim processing code adjustments, with advance notice to providers, and implementation of code changes after insurance systems are updated.

- Requiring standardized and regulated claim auditing protocols to reduce provider audits and monetary claw-backs from providers.

We urge you to support SB 360 and HB 5391, with the incorporation requested changes of Marriage and Family Therapists, as well as other mental health professionals to better serve Connecticut residents in desperate need of mental health treatment.

Please do not hesitate to reach out if I can be of further assistance at advocacy@ctamft.org. Thank you for your time on this important matter.

Sincerely,

Rebecca Ruitto, LMFT

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Chair, CTAMFT